

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

**E R R A T A**

TO: ALL COUNTY WELFARE DIRECTORS

**SUBJECT: CORRECTION TO CA 8 (5/97), STATEMENT OF FACTS FOR
ADDITIONAL PERSON, THE SUPPLEMENTAL APPLICATION FOR
FOOD STAMPS AND REQUEST FOR CASH AID**

REFERENCE: ALL COUNTY INFORMATION NOTICE I-43-97 DATED JULY 21, 1997

This Errata transmits a copy of the CA 8 with a revision date of 8/97, which corrects technical errors in the subset items outlined below:

- Page 1, Item 6: The narrative "If YES, complete below" is corrected to "Complete below."
- Page 4, Item 23B: The narrative "If YES, check each item. . ." is changed to "If YES, list each item. . ."
- Page 5, Item 32B: The narrative "If YES, who," is changed to "If YES, how much does he/she pay each month?"

No stock was made of the CA 8 (5/97).

We apologize for any inconvenience this has caused.

STATEMENT OF FACTS FOR ADDITIONAL PERSON*(Supplemental Application for Food Stamps and Request for Cash Aid)*

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" for food stamps listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

For Food Stamp households, which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

PLEASE PRINT IN INK

CA ① Name of Person Completing Form (First, Middle, Last)
FS

CA ② List new person in the home, including a newborn.
FS

NAME (First Middle Last)		CITIZEN/NON-CITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Lawful non-citizen <input type="checkbox"/> Undocumented non-citizen <input type="checkbox"/> Sponsored <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other:	
SOCIAL SECURITY NUMBER	BIRTHDATE	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
BIRTHPLACE (City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Not Attending School (Explain):	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)	

CA ③ Has he/she applied for or received benefits in the past, such as: cash aid, food stamps homeless assistance, Medi-Cal, Refugee Cash Assistance? ☐ YES ☐ NO
FS If "YES", explain:

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA ④ Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

MOTHER'S NAME (✓) Lives in Home	FATHER'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply) <input type="checkbox"/> Absence <input type="checkbox"/> Unemployment <input type="checkbox"/> Incapacity <input type="checkbox"/> Death
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

CA ⑤ Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain: ☐ YES ☐ NO
FS

LIST NAME, BRANCH OF SERVICE, ETC.	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO
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CA ⑥ Has he/she lived in California for the last 12 months in a row? Complete below: ☐ YES ☐ NO

LAST PLACE OF RESIDENCE (City, State)	DATE ARRIVED IN CALIFORNIA

CA ⑦ Does he/she presently live in California and intend to continue living here? If "NO", explain: ☐ YES ☐ NO

COUNTY USE ONLY

CASE NAME	VERIFIED:	YES	NO
CASE NUMBER	SSN		
WORKER NAME	FS ID		
WORKER NUMBER	Blind/Deaf/Disabled		
DATE RECEIVED	Residency		
	DFA 285-C Comp.		
	Referred to Cal-Learn		
	CA 25 Completed		
	CA 25 A Completed		
	Referred to GAIN		
	Citizen		
	Eligible Non-citizen		
	Sponsored		
	SAVE		
	Date of Entry to U.S.		
	Excluded HH Member Code		
	Work/Training/GAIN Code		

VERIFIED: Deprivation ☐ YES ☐ NO

CA 5 ☐ YES ☐ NO

Date Initiated _____

Apply RFG: ☐ YES ☐ NO

State _____
RFG MAP _____
RFG Months _____

COUNTY USE ONLY																
CA FS	(8) A. Is he/she a foster child(ren) living in the home? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>	<input type="checkbox"/> AFDC and FC Eligible/ CR Chooses: Child: <input type="checkbox"/> AFDC <input type="checkbox"/> FC CR: <input type="checkbox"/> AFDC <input type="checkbox"/> None														
FS	B. Do you want the foster child and their foster care income included in the Food Stamp case? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
CA FS	(9) A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No FS Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td style="width: 20%;">UNITS/HOURS PER WEEK</td> <td style="width: 20%;">EXPECTED DATE OF GRADUATION</td> <td style="width: 30%;">WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="4" style="padding: 5px;"> IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify): </td> </tr> </table>		NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):										
NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO													
IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):																
CA FS	B. Complete below if he/she is enrolled in college or attending a similar educational institution.															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter</td> <td style="width: 30%;">TUITION/FEES PER TERM \$</td> <td style="width: 40%;">BOOKS, EQUIPMENT, ETC., PER TERM \$</td> </tr> <tr> <td>ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)</td> <td>DAYS ATTENDING PER WEEK</td> <td>TRANSPORTATION USED</td> </tr> <tr> <td>TRANSPORTATION COST PER WEEK \$</td> <td>AMOUNT PAID BY CARPOOL MEMBERS \$</td> <td>PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY \$</td> </tr> </table>		TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED	TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY \$	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No					
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$														
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED														
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY \$														
CA FS	(10) Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? If "YES", complete below: <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">WHY</td> <td style="width: 30%;">WHEN</td> <td style="width: 40%;">WHAT COUNTY/STATE</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </table>		WHY	WHEN	WHAT COUNTY/STATE												
WHY	WHEN	WHAT COUNTY/STATE														
CA FS	(11) Is he/she hiding or running from the law for a felony, an attempted felony, or for a parole or probation violation? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
FS	(12) Does he/she buy food and fix meals separately from others in the home? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
			Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No													
FS	(13) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
			Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No													
FS	(14) Does he/she pay you for meals and/or a room? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div>															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both</td> <td style="width: 20%;">HOW MUCH \$</td> <td style="width: 20%;">HOW OFTEN</td> <td style="width: 30%;">NO. OF MEALS PER DAY</td> </tr> </table>		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">Household Elects</td> </tr> <tr> <td style="width: 33%;">BOARDER</td> <td style="width: 33%;">HH MEMBER</td> <td style="width: 33%;">ROOMER</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </table>		Household Elects			BOARDER	HH MEMBER	ROOMER			
CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY													
Household Elects																
BOARDER	HH MEMBER	ROOMER														
FS	(15) Does he/she get food from any of the following programs? <div style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <ul style="list-style-type: none"> • Communal dining facility for the elderly or disabled • Food distribution program operated by a Native American reservation • Other food program If "YES", complete below:															
NAME OF PROGRAM																

CA 16 Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. ☐ YES ☐ NO
FS (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).

COUNTY USE ONLY

(✓) If Exempt

☐ CA
☐ FS Adult
☐ FS Child

FS S/E Farmer ☐ Yes ☐ NoVerification(s) on file: ☐ Yes ☐ No

EMPLOYER NAME	SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	OCCUPATION	DAYS/HOURS WORKED PER MONTH
PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ <input type="checkbox"/> NO	

CA 17 A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? ☐ YES ☐ NO
FS If "YES", complete below:

Child Care Informing
Given to Client:

Trustline Informing (CCP 2)	Health & Safety Certification (CCP 5)
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☐ Yes ☐ No ☐ Yes ☐ No

Dependent Care Eligible

CA <input type="checkbox"/> Yes <input type="checkbox"/> No	FS <input type="checkbox"/> Yes <input type="checkbox"/> No
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NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID \$
NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID \$

CA B. Does he/she get child care costs paid for them? ☐ YES ☐ NO
FS Include costs paid by a relative or friend, Department of Education, Student Aid Block Grant, Cal-Learn, TCC, NET, GAIN, SCC, CAAP, etc. If "YES", complete below:

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$

CA 18 Has he/she stopped or refused work or training in the last 60 days? ☐ YES ☐ NO
FS If "YES", complete below:

	YES	NO
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Emp. Statement

Good Cause Determ

Voluntary Quit

☐ CA: 30 days☐ FS: 60 days

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFORE DEDUCTIONS \$
	EXPECTED CHECK (DATE)	AMOUNT BEFORE DEDUCTIONS \$
	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ <input type="checkbox"/> NO	
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____	LAST DAY OF WORK/TRAINING	REASON FOR LEAVING JOB/TRAINING

CA 19 Is he/she on strike? ☐ YES ☐ NO
FS If "YES", complete below:

Striker Regs Apply

CA

FS

☐ Yes ☐ No ☐ Yes ☐ No

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	NAME OF UNION
	DATE WENT ON STRIKE
	GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE \$

CA 20 Does he/she pay child or spousal support? ☐ YES ☐ NO
FS If "YES", complete below:

Court Order on File ☐ Yes ☐ No

Amount Ordered

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH \$	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO
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CA 21 Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? ☐ YES ☐ NO
FS If "YES", complete below:

TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly, Etc.)	DATE EXPECTED TO START AND STOP	(✓) If Exempt
		\$				START:	CA FS
						STOP:	

CA 22 Does he/she own or is he/she buying any real estate, such as land <input type="checkbox"/> YES <input type="checkbox"/> NO FS and/or buildings anywhere, including outside the U.S.? If "YES", complete below:						COUNTY USE ONLY Home Exempt <input type="checkbox"/> Yes <input type="checkbox"/> No Other Real Property Market Value \$ _____ Amount Owed \$ _____ Net Value \$ _____ Lien Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No	
TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED			
			\$	\$			

CA 23 A. Does he/she have any of the following resources? <input type="checkbox"/> YES <input type="checkbox"/> NO FS If "YES" check (✓) each item and explain below:					
RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt	
				\$	AFDC	FS
				\$		

CA B. Does he/she get income from any of these resources, such as <input type="checkbox"/> YES <input type="checkbox"/> NO FS interest, dividends, etc.? If "YES," list each item and explain below:		
SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA 24 Does he/she own, lease, or use any motor vehicles, such as a <input type="checkbox"/> YES <input type="checkbox"/> NO FS car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.? If "YES", complete below:							(✓) If Exempt Leased	Vehicle Valuation
NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED	<input type="checkbox"/> Exempt	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	<input type="checkbox"/> Leased	

CA 25 Does he/she own or use <u>personal property</u> which cost at least \$100 for <input type="checkbox"/> YES <input type="checkbox"/> NO FS each item or is now worth at least \$100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings. If "YES", complete below:						<input type="checkbox"/> Owned Jointly <input type="checkbox"/> Owned Separately Net Market Value \$ _____
OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED		
			\$	\$		
			\$	\$		

CA 26 Has he/she sold, transferred or given away any real or personal property <input type="checkbox"/> YES <input type="checkbox"/> NO FS within the last 2 years for cash aid and within the last 3 months for food stamps? If "YES", explain below:		Closed Bank Accounts: <input type="checkbox"/> Food Stamps in last 3 months
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CA 27 Does he/she have any of the following insurance coverage: life, burial, disability or mortgage? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:				Total CSV (1) _____ (2) _____ Total Countable Property: Items 22-27 AFDC \$ _____ FS \$ _____
NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID	
			\$	

CA 28 Does he/she have health or hospitalization insurance, including insurance <input type="checkbox"/> YES <input type="checkbox"/> NO FS paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.? If "YES", complete below:				<input type="checkbox"/> Health Care Options Explanation Given Referral _____ NA _____ <input type="checkbox"/> DHS 6155 <input type="checkbox"/> DFA 285-C Medicare Gross Premium \$ _____
NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID	
		\$		

CA 29 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						COUNTY USE ONLY		
NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?		Retro Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Approved <input type="checkbox"/> Yes <input type="checkbox"/> No		
		YES	NO	YES	NO			
CA 30 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						<input type="checkbox"/> DHS 6155		
NAME OF INSURANCE COMPANY	PREMIUM AMOUNT		HOW OFTEN PAID					
	\$							
CA 31 Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						VERIFIED: Higher/Lower MAP <input type="checkbox"/> Yes <input type="checkbox"/> No Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C		
TYPE OF PROBLEM	DATE PROBLEM STARTED		EXPECTED DATE OF RECOVERY					
CA 32 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item YES or NO:						CA Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ VERIFIED: CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C		
	YES	NO		YES	NO			
Special diet--prescribed by a doctor			Very high use of utilities					
Special transportation need			Special laundry service					
Special telephone or other equipment			Other (specify):					
Housework (no one in the home can do it)								
If "YES", explain:								
CA B. Does he/she get In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", how much does he/she pay each month? \$ _____						<input type="checkbox"/> DFA 285-C		
FS								
CA 33 The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. Check (✓) each item YES or NO.						<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> Referral		
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.								
• Do you want more information about CHDP Services? • Do you want CHDP medical services? • Do you want CHDP dental services? • Do you need help making appointments or with transportation to CHDP Services?						YES	NO	
B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?								
C. Is anyone in the family breastfeeding a child? If "YES", was the birth within the last 12 months? If "YES" checked to 33 B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.								
D. Do you or any family member want free or low-cost family planning services? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.								
						<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date _____		

CERTIFICATION

I understand the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may also be fined up to \$5,000 and/or sent to jail/prison for 3 years.
- If I give false or incomplete facts, I may be fined or sent to jail or prison if I am found guilty of committing perjury.
- If I file more than one application for cash aid so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.
- If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;
 - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
 - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever;
 - I gave the county false identity or residence information so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

I also understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.
- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, etc.
- A Social Security Number (SSN) is required by law and will be matched with other records to be sure that I am not getting aid in more than one case, or in another county or state.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution, may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get food stamps.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT IN THE HOME, IF APPLYING FOR CASH AID)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT	DATE
EW SIGNATURE	DATE